Trends in Health Care Organizations

Sara Rosenbaum, J.D.
Harold and Jane Hirsh Professor,
Health Law and Policy
Peter Shin, Ph.D.
Senior Research Scientist
The George Washington University Medical Center
School of Public Health and Health Services
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Key Issues

- Population trends
- Health care costs
- Insurance coverage
- Overall revenue trends
- Health care technology
- The health care workforce
- Health care quality improvement efforts

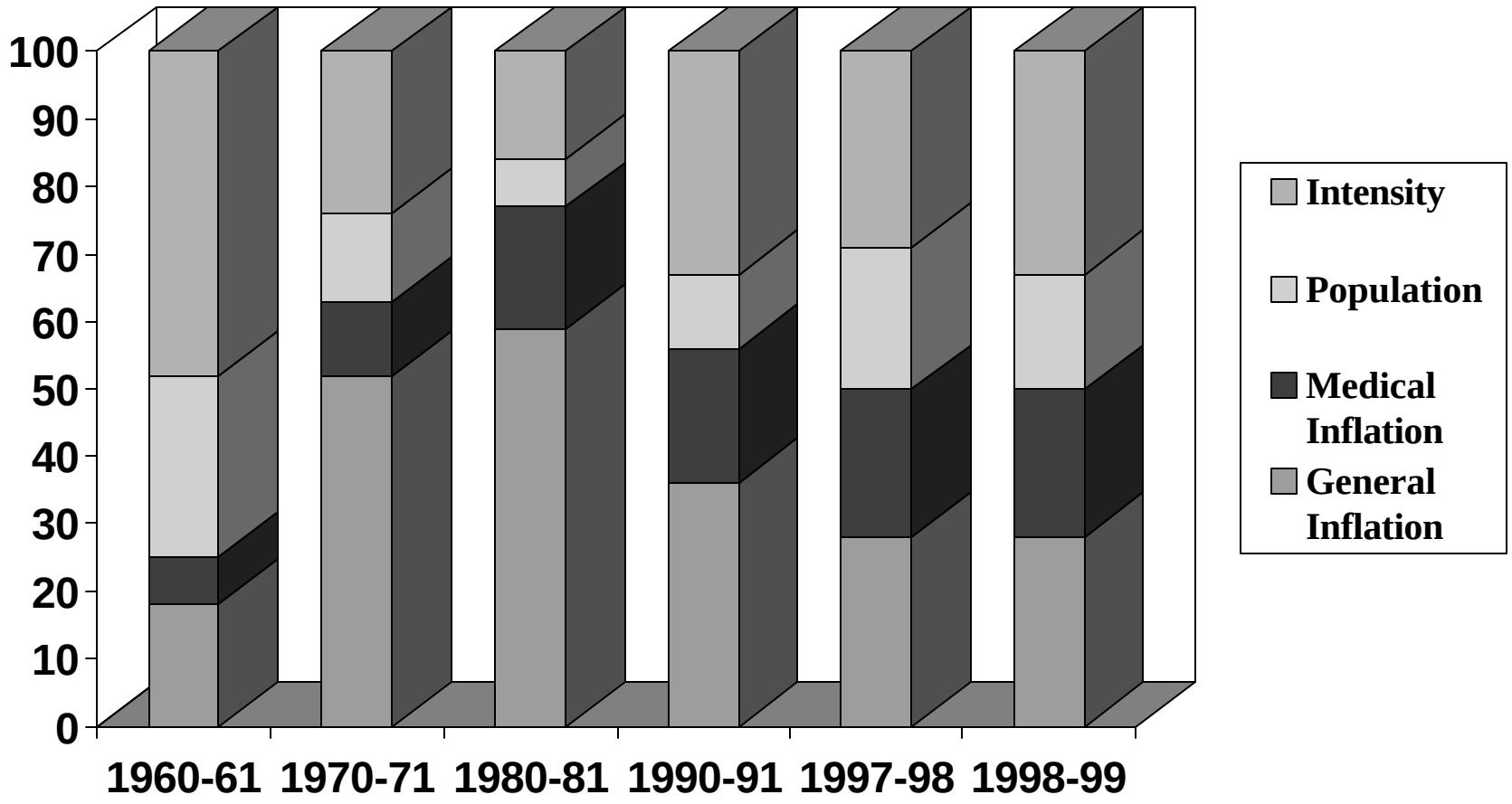
Population Trends

More expensive patients

- Doubling of the elderly population
- Greater survival among persons with disabilities
- Greater levels of co-morbidity and chronic conditions

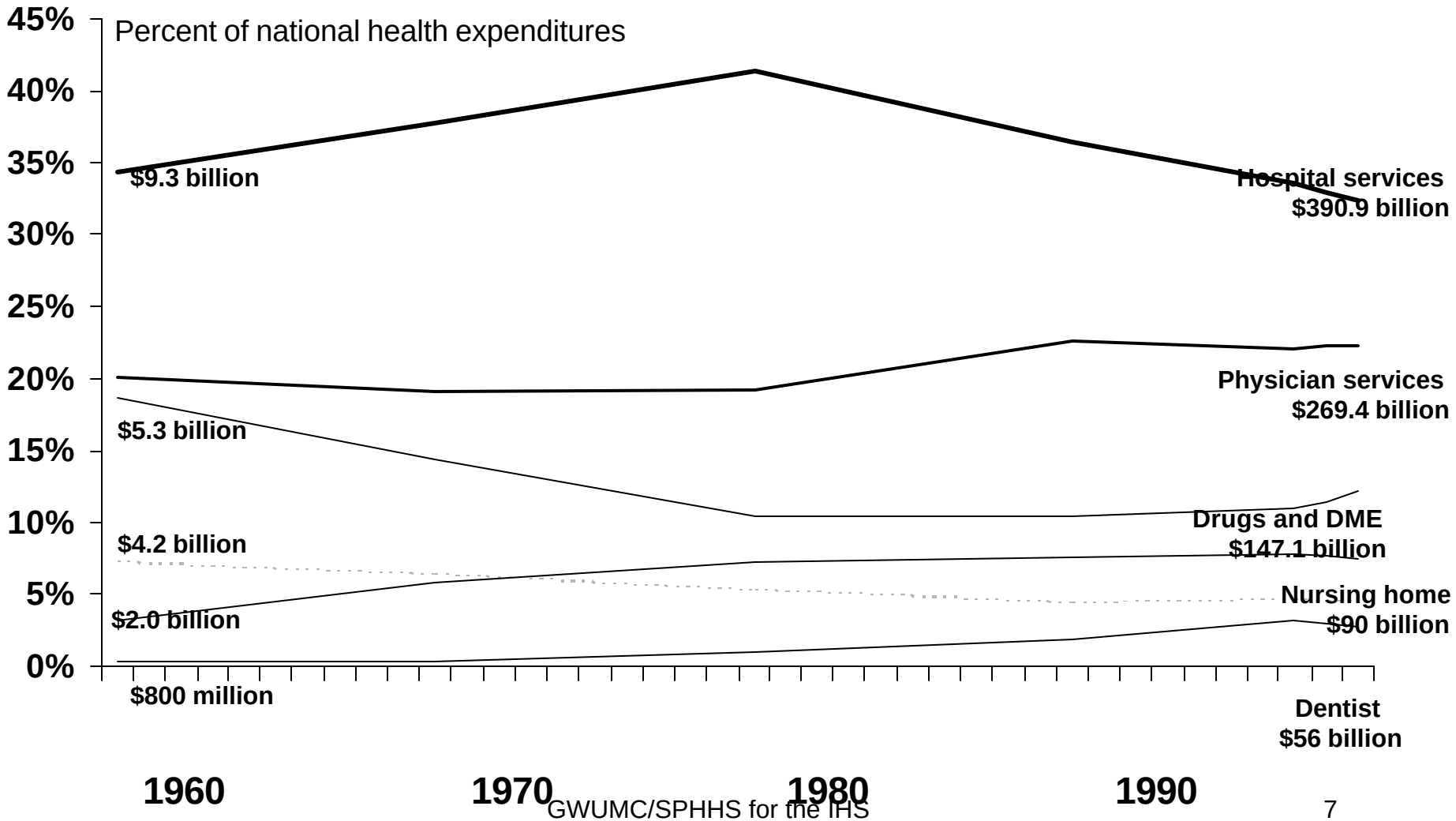
Health Care Costs

Growth in Personal Health Care Expenditures and Percent Distribution of Factors Affecting Growth, 1960-1999



Source: Health, United States, 2001.

Personal Health Care
By Type of Expenditure, 1960-1999

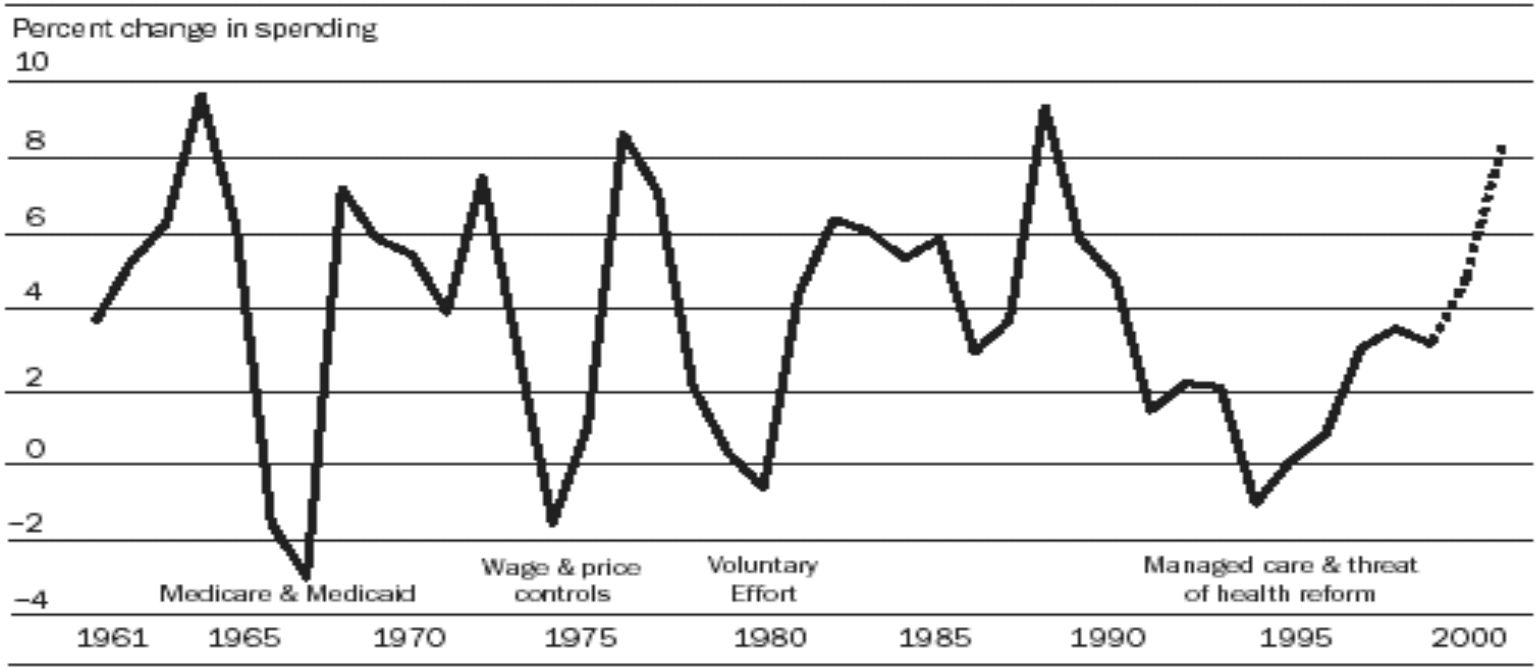


Source: Health, United States, 2001.

Figure 20. Annual Change in Private Spending, 1961-2000

EXHIBIT 1

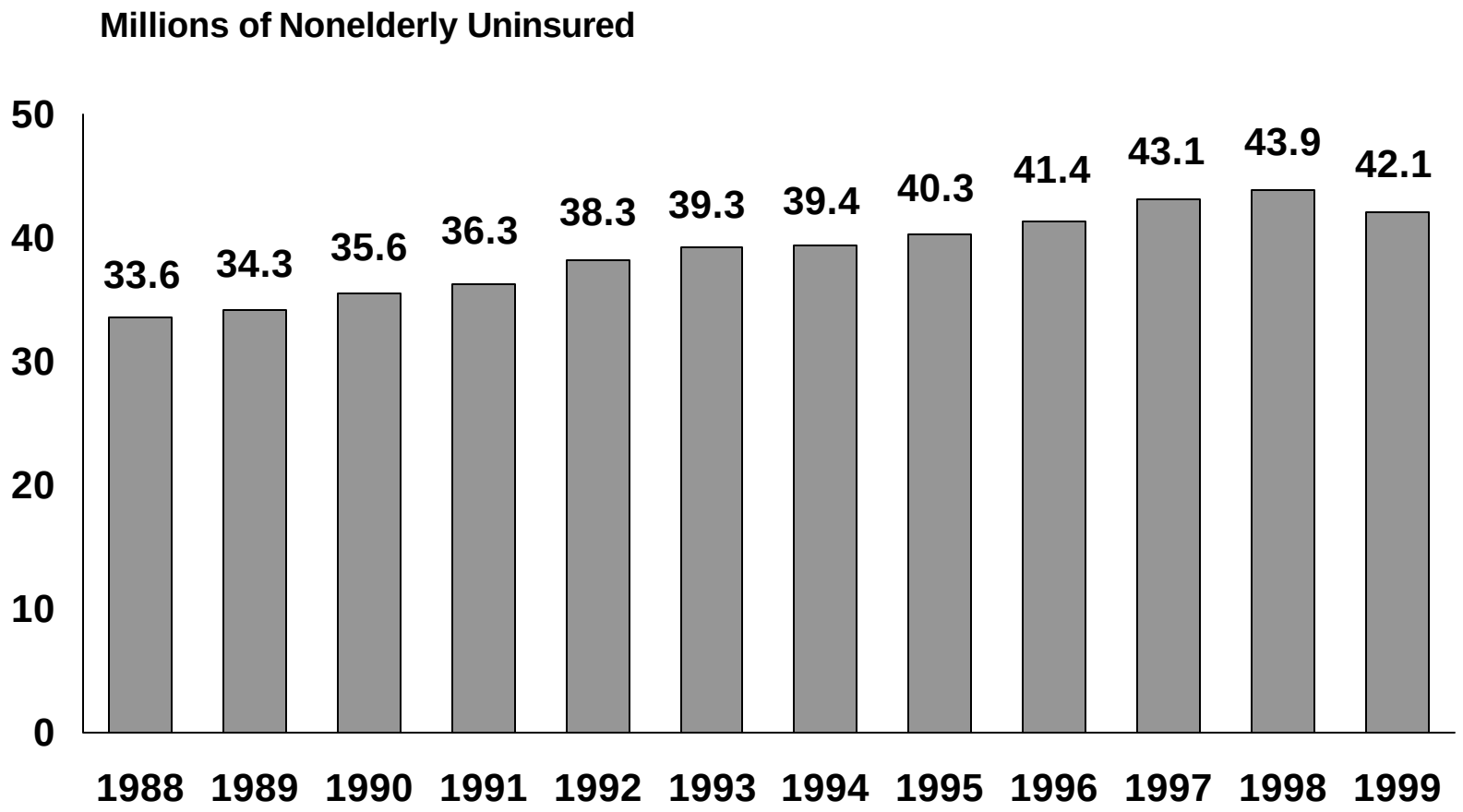
Annual Change In Private Health Spending Per Capita (Adjusted For Inflation), 1961–2001



SOURCES: Henry J. Kaiser Family Foundation analysis. Private health expenditures per capita, 1960–1999, are from the Centers for Medicare and Medicaid Services (CMS). Change in private spending per capita, 2000–2001, is estimated based on average premium increases for employer-sponsored coverage from the Kaiser/HRET Survey of Employer-Sponsored Health Benefits.
NOTES: Real change in spending is calculated using the Consumer Price Index (CPI-U) all items, average annual change for 1961–2000 and July-to-July change for 2001. This analysis was inspired by an analysis done by Jeff Merrill and Richard Wassermann more than fifteen years ago. See J.C. Merrill and R.J. Wassermann, "Growth in National Expenditures: Additional Analyses," *Health Affairs* (Winter 1985): 91–98.

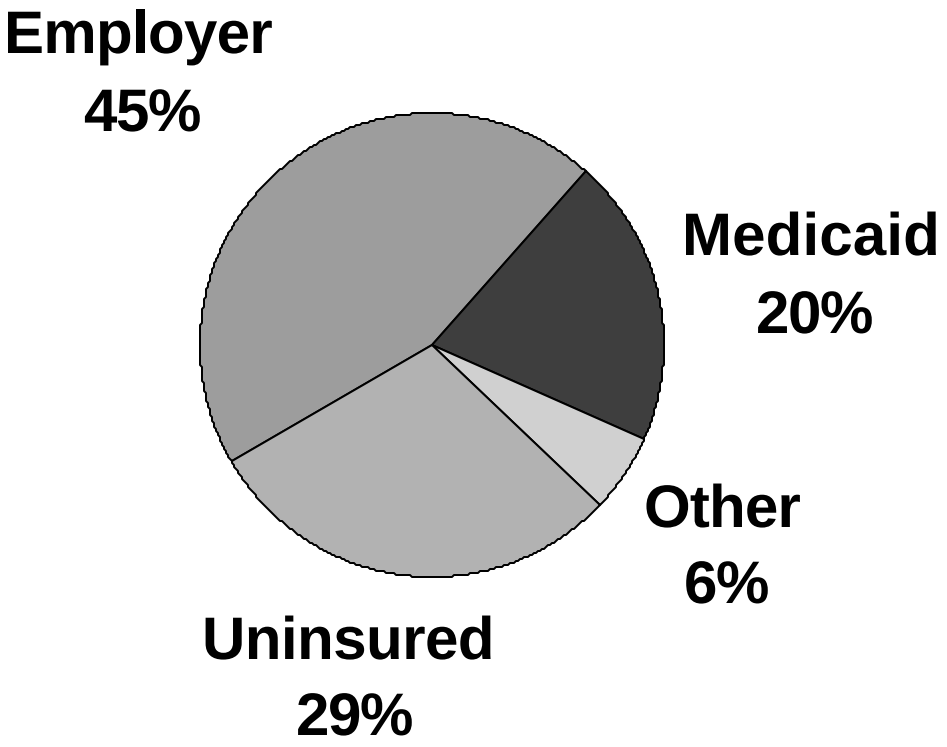
Health Insurance

Growth in the Number of Uninsured Americans 1988-1999



Kaiser Commission on Medicaid and the Uninsured
SOURCE: Employee Benefits Research Institute, 2000.
DATA: CPS, 2000.

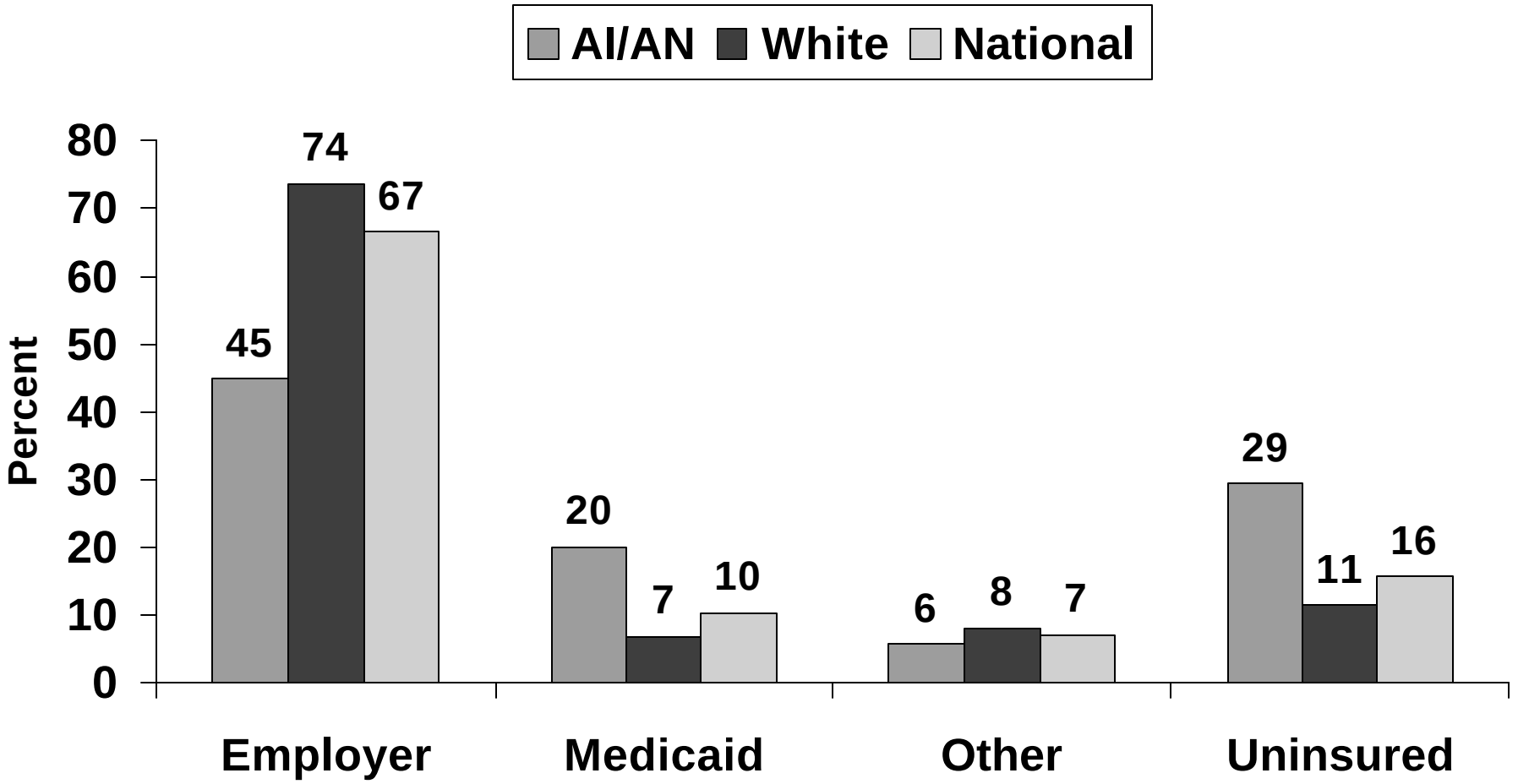
Health Insurance Status of Non-elderly American Indians and Alaska Natives



N = 2.3 million

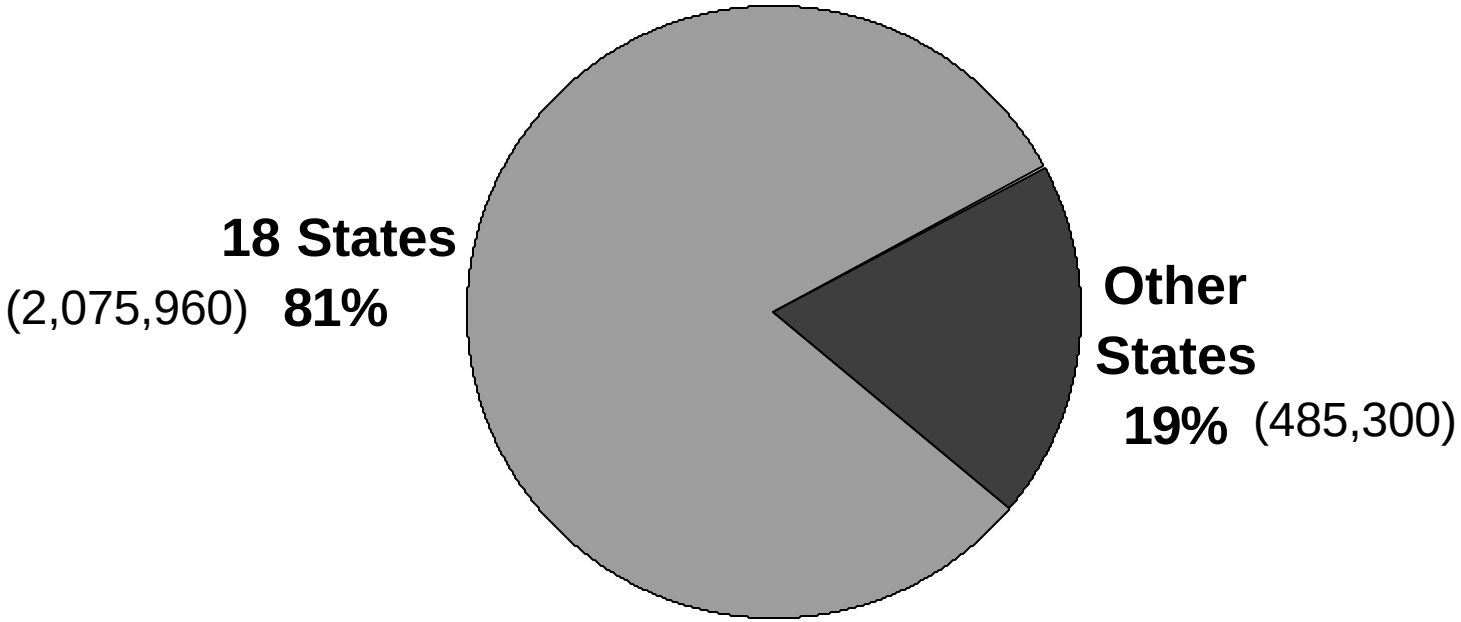
Source: Kaiser Commission on Medicaid and the Uninsured, Health Insurance Coverage in America, 2000 Data Update.

Health Insurance Status by Race/Ethnicity



Source: Kaiser Commission on Medicaid and the Uninsured, Health Insurance Coverage in America, 2000 Data Update.

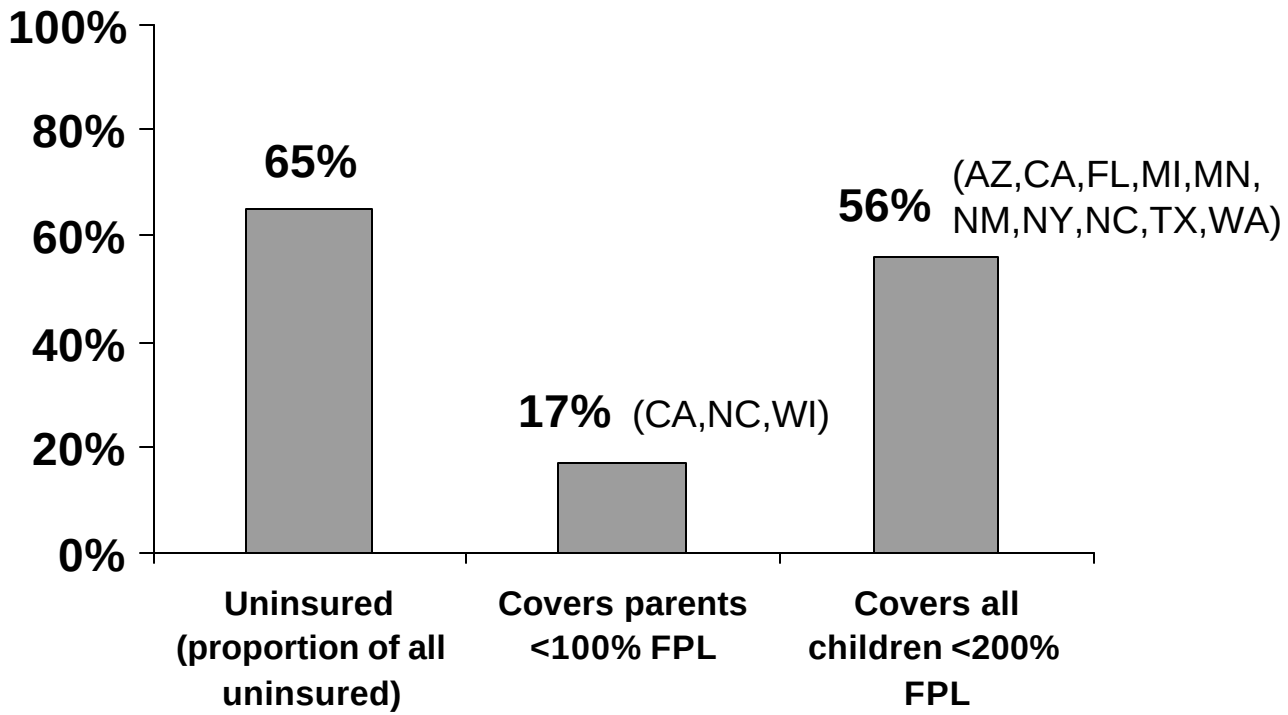
State Residency Patterns of American Indian and Alaskan Native



N=2,561,260

18 States: AK, CA, FL, IL, MI, MN, MT, NM, NY, NC, ND, OK, OR, SD, TX, WA, and WI
Source: Kaiser Commission on Medicaid and the Uninsured, Health Insurance Coverage in America, 2000 Data Update.

Medicaid/SCHIP Eligibility Policy in the 18 Highest AI/AN States



Source: Uninsured data based from Kaiser Commission on Medicaid and the Uninsured, Health Insurance Coverage in America, 2000 Data Update. Eligibility information provided by the Center for Health Services Research and Policy and the American Academy of Pediatrics.

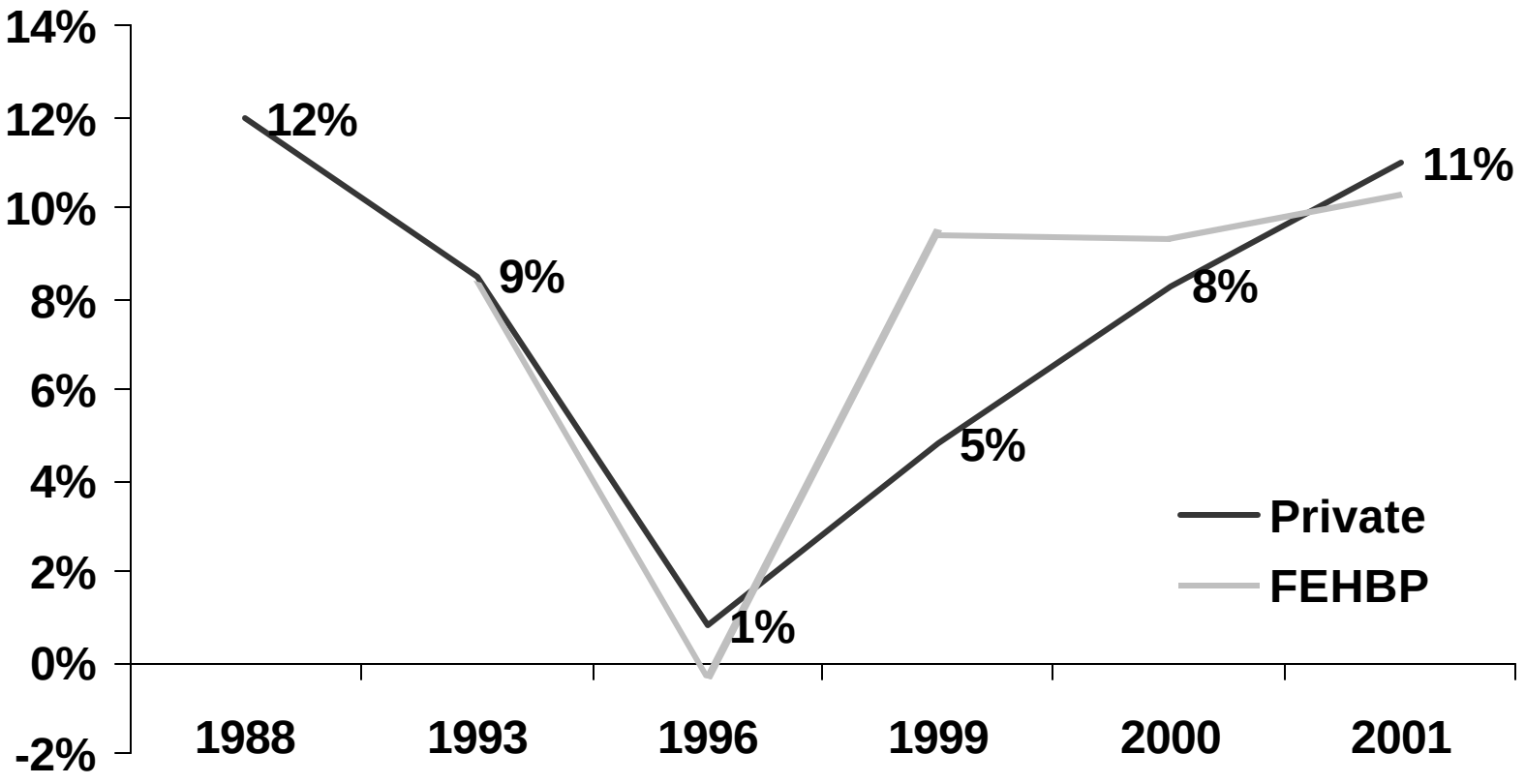
The “New” Health Insurance

- More limited benefits
- Higher cost sharing and premiums
- Disease management emphasis with defined treatment pathways as coverage limits
- Not just private insurance: reinvention of Medicaid through HIFA, particularly for non-disabled adults

Revenues

- Two basic rules:
  - Revenues of health care organizations overwhelmingly are derived from public and private insurance payments.
  - Insurance payments rise at a much faster rate than general inflation.

Annual Rate Increases for Health Insurance Premiums

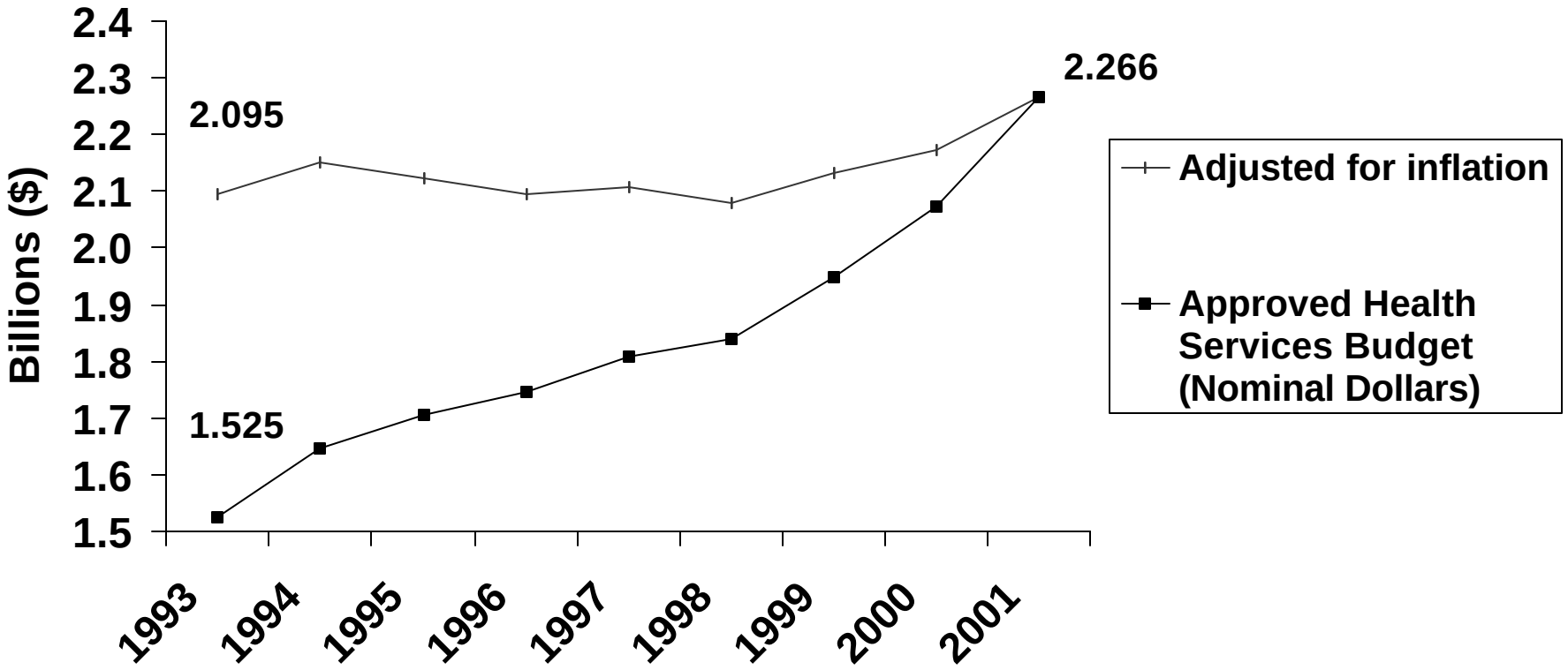


Sources: Kaiser/HRET Health Benefit Survey 2000; Office of Personnel Management.

Revenues (cont.)

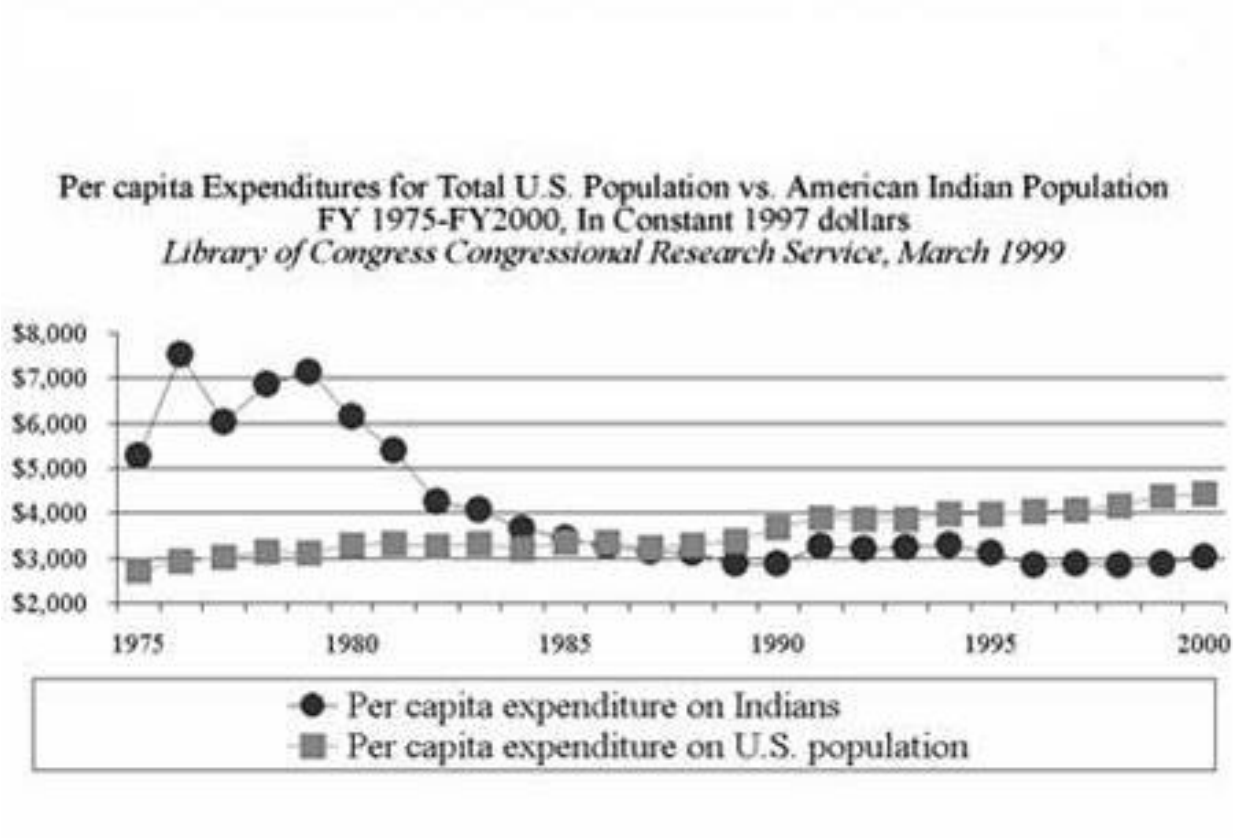
- The challenges confronting the IHS
  - About 15% of total revenues come from public insurance payments ($450 million out of a total of $3.05 billion in total revenues in FY 2001)
  - The vast majority of financing comes from annual discretionary appropriations, which are growing much slower than the rate of medical inflation.

IHS Appropriations, FY1993 – FY2001: Nominal and Adjusted for Inflation



Source: FY 2002 IHS Budget: Analysis and Recommendations, Northwest Portland Area Indian Health Board

Federal spending for AI/AN Programs, FY1975 - FY2000
(Adjusted for Medical Inflation)

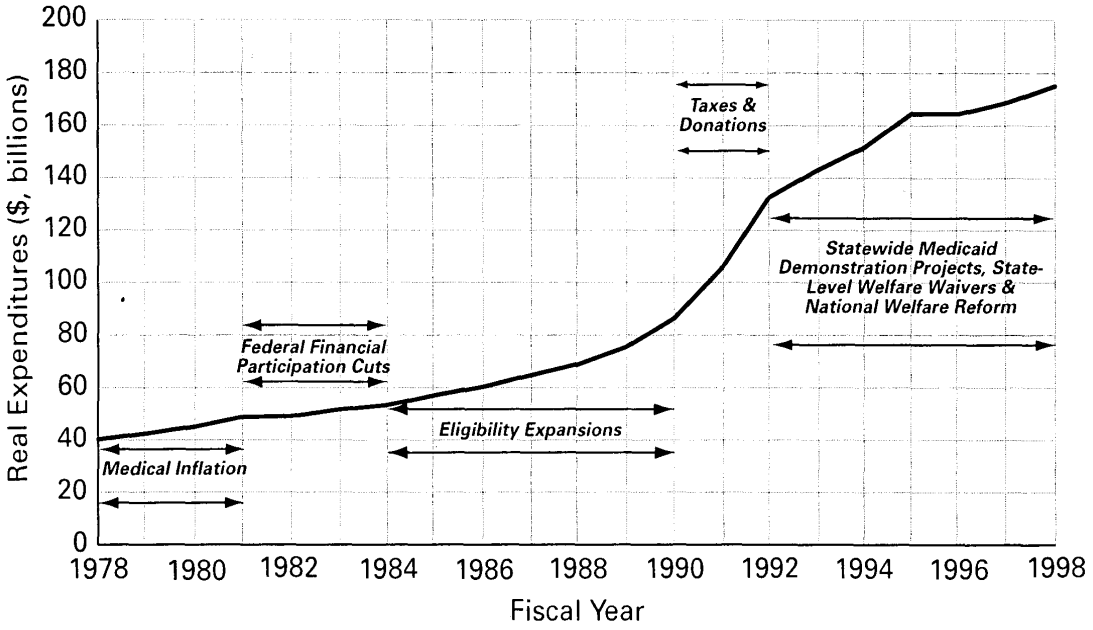


Reconceptualizing the Health Care Organization

- Diversify the revenue base and understand health care purchasing patterns: where are the revenues?
- The VA lesson: decentralize operations and reconceptualize service activities as part of a health systems enterprise rather than as individual service components (e.g., hospital care)
- Partner with other entities in additional markets (e.g., VA, selected employers)
- Stimulate insurance coverage, public and private

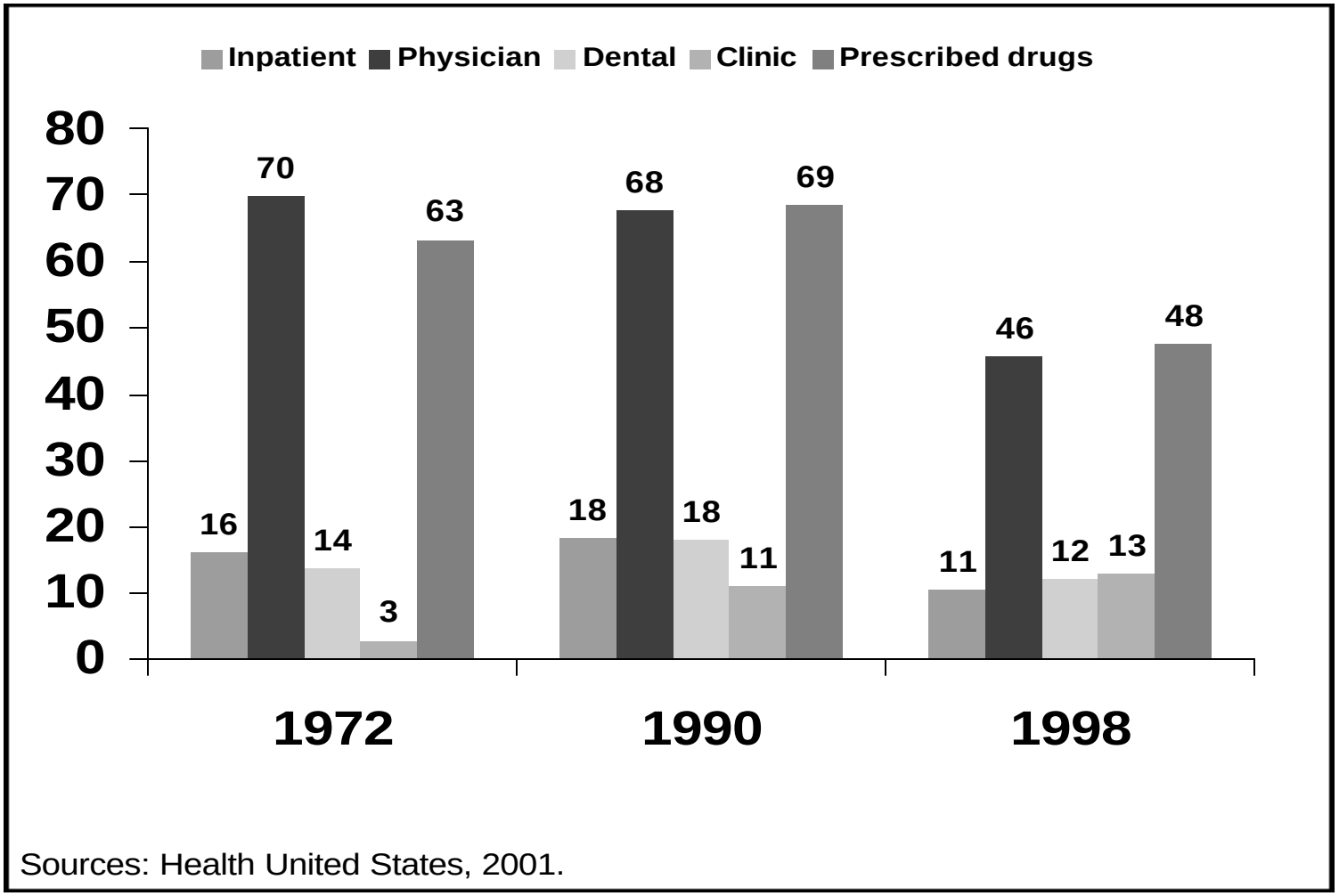
Importance of Reconceptualization From A Financial Standpoint

- Medicaid expenditure trends show the need to think of systems of care



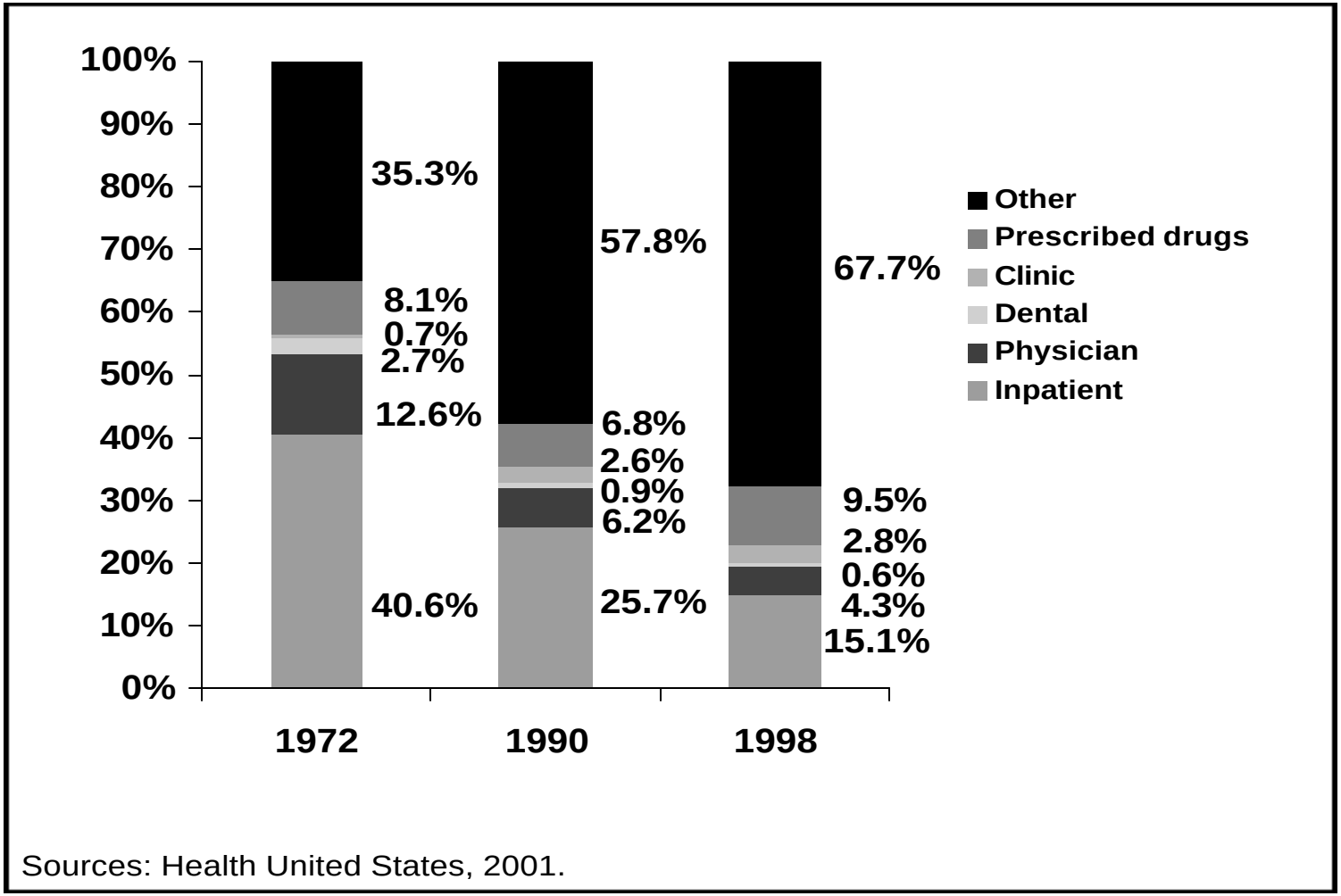
Note: The data shown above are expressed in 1998 dollars.
Source: Profile of Medicaid Chartbook 2000. DHHS, HCFA, 2000.
Figure 2.3 "Total Medicaid Spending by Era"

Medicaid Spending, 1972-1998: Recipients (millions), Selected Services



Sources: Health United States, 2001.

Medicaid Spending, 1972-1998: Proportional Expenditures, Selected Services



Sources: Health United States, 2001.

Health Care Technology

- Ambulatory care
- Disease management and treatment pathways
- Brief therapies/emphasis on prescribed drugs

Health Care Workforce

- A looming shortage of primary care and sub-specialties?

Health Care Quality Improvement

- Capabilities in inputs and outcomes
- Accreditation
- Compensation tied to achievement of prevention goals and “low prevalence” disease management capabilities